ADMINISTRATION OF PROSTAGLANDIN FOR CERVICAL RIPENING/INDUCTION OF LABOUR

OPTIMAL OUTCOMES
- Successful induction of labour
- Improved cervical status enabling artificial rupture of the membranes

PATIENT
- Women in whom induction of labour is indicated, are at term with a singleton cephalic pregnancy and valid consent for induction has been obtained.

CONTRAINDICATIONS
- Allergy to prostaglandins
- Major placenta praevia or vasa praevia
- Previous hysterotomy
- Previous classical or lower segment Caesaean section (rate of uterine rupture up to 5.6%)(1)
- Previous myomectomy
- Grand multiparity (para ≥ 5)
- High suspicion of cephalo-pelvic disproportion
- Malpresentation
- Multiple pregnancy
- Ruptured membranes
- Unexplained antepartum haemorrhage
- History of severe asthma, glaucoma, cardio-vascular, hepatic or renal disease

Prostaglandin gel may be given to women with ruptured membranes or previous APH after review by senior registrar or a consultant.

Administration may normally be undertaken in Antenatal Ward except for women with evidence of maternal or fetal compromise; These patients will require increased monitoring and are to be cared for in delivery suite.

STAFF
- Prostaglandin gel to be administered by staff member capable of performing vaginal examination competently
- Prostaglandin gel may only be prescribed by a consultant obstetrician or a registrar who has written permission to do so from the Director of Obstetrics
- Residents are not allowed to prescribe Prostaglandin gel

EQUIPMENT
- CTG equipment
- Prostaglandin gel (at room temperature)
- Water-based lubricant (not Hibitane)
- Sterile gloves

PROCEDURE
- Maternal-fetal assessment; including confirmation of gestation and presence of any contraindications.
- Woman to be admitted by Resident
- Explain procedure to woman
- Record normal CTG prior to insertion of Prostaglandin gel
- Perform vaginal examination and record Bishop’s score. Prostaglandin gel can be given when the Bishop score ≤ 7.
- Insert Prostaglandin gel (1mg or 2 mg) into the posterior or lateral vaginal fornix, avoiding the cervix
- Record CTG following insertion of Prostaglandin for 40 minutes, continue to monitor if trace is non-reassuring.

cont’d ..../2
ADMISTRATION OF PROSTAGLANDIN FOR CERVICAL RIPENING/INDUCTION OF LABOUR cont’d

TIMING OF DOSAGES
Following schedule to be used unless otherwise specified by consultant:
Nulliparous women; 2mg in the morning, followed by 1mg, 6 hours later.
Multiparous women 1 mg in the afternoon.

Consultants may request alternate dosage times.

The 2nd dose of gel is not to be administered if there are regular & painful uterine tightenings; the dose can be given if this activity settles.
The Cervix is reassessed at 6am the following morning; if the membranes are able to be ruptured, the woman is transferred to Delivery Suite. If Bishop score <7; for medical review.

HAZARDS/UNWANTED OUTCOMES
• Non reassuring fetal heart rate pattern
• Hypertonic uterine activity – in the event of hypertonic uterine activity notify registrar/consultant. Prepare bolus of Salbutamol (Dilute 1ml Salbutamol (5mg in 5mls) with 9ml normal saline to make a solution of 100mcg per ml; give 1-3ml as slow IV push) or Terbutaline 0.25mcg subcutaneously (1).
• Nausea/Vomiting
• Diarrhoea
• Vaginal irritation
• Dyspnoea
• Pyrexia
• Uterine rupture
• Hypertension
• bronchoconstriction
• headaches, epigastric & chest pain
• allergic reaction

DOCUMENTATION
• Prostaglandin gel should be prescribed in appropriately completed medication chart.
• Record Bishop’s score and CTG findings in women’s clinical progress notes and on CTG trace

EDUCATIONAL NOTES
• Prostaglandin gel can cause uterine activity without cervical changes (2); sedation and analgesia may be required to allow the woman to sleep overnight.
• There is no evidence which suggests an optimal timing of doses (3).
• The literature supports the use of prostaglandins as an effective agent for inducing labour with both favourable and unfavourable cervices (4)(5).

RELATED POLICIES/PROCEDURES
• Policy: Induction of Labour
• Policy: Management of Prolonged Pregnancy

cont’d ..../3
INDUCTION OF LABOUR for BIRTH CENTRE PATIENTS

OPTIMAL OUTCOME: That the labour is induced using Prostaglandin gel, and the patient transferred to the Birth Centre, in established labour and births in her place of choice.

- Management of a post dates pregnancy is the usual reason a Birth Centre client is admitted for IOL.
- The patient must continue to meet the Birth Centre’s criteria for inclusion into its program. If she does not, her care is transferred to the Medical Staff and she will birth in the Delivery Suite.
- The Induction of labour is booked with the Birth Centre, Delivery Suite and Antenatal ward.
- The current Prostin regime is followed.
- The Birth Centre midwives are kept informed of progress and transfer occurs when labour has established.
- If the Bishop Score exceeds 7 and contractions have not commenced, the woman is transferred to the Delivery Suite for Artificial Rupture of membranes.
- If contractions establish within (4 hours) she is transferred to the Birth Centre, otherwise a Syntocinon infusion is commenced and she remains in the Delivery Suite.
- The woman and her partner are informed of the options for care, depending upon the effectiveness of the prostaglandins and need to be reassured that, where feasible, their wishes will be accommodated.
- Obstetric registrar, Birth centre and Delivery Suite staff are informed of progress.

REFERENCES: